Model of Care

Objectives

- Medicare/Medicare Advantage 101
- Outline the basic concepts of Special Needs Plans
- Identify the requirements for success
- Describe the purpose and key components of the Model of Care
  - Health Risk Assessments (HRA)
  - Individualized Care Plans (ICP)
  - Interdisciplinary Care Team (ICT) Meetings
  - Care Transition Protocols
- Plan communications

Medicare/Medicare Advantage 101

Simpra Advantage
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Medicare

Federal system of health insurance for people over 65 years of age and for qualifying individuals younger than 65 years of age with disabilities

- **Part A (Hospital Insurance)**
  - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Part B (Medical Insurance)**
  - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Part D (Prescription Drugs)**
  - Part D Covers certain outpatient prescription drugs

Medicare Advantage

- **Health Plan Options**
  - Medicare Advantage (MA)
  - Medicare Advantage-Prescription Drug (MA-PD)
  - Special Needs Plan (SNP)
- **Part C (Medicare Advantage)**
  - All Part A and Part B Covered Services (A+B=C)
  - Some plans may provide additional benefits
- **Part D (Prescription Drugs) Outpatient Prescription Drug Coverage**
- **Medicare Advantage-Prescription Drug (MA-PD) Program (Part C + Part D)**

Special Needs Plan

A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals.

I-SNP

(Institutional Special Needs Plan)

IE-SNP

(Institutional Equivalent Special Needs Plan)

D-SNP

(Dual-eligible Special Needs Plan)

Institutional Special Needs Plan (I-SNP)

Who can join an I-SNP?

- Entitled to Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Lives in Plan service area (Facility)
- Must reside (OR is expected to reside) in a contracted assisted living facility (ALF), specialty care assisted living facility (SCALF) or skilled nursing facility (SNF) for greater than 90 days at time of enrollment

Institutional-Equivalent Special Needs Plans (IE-SNPs):

For an I-SNP to enroll MA eligible individuals living in an ALF or a SCALF, the following two conditions must be met:

1. A determination of institutional LOC that is based on the use of a state assessment criteria. The assessment criteria used for persons living in the community must be the same as that used for individuals residing in an institution.
2. The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

Dual-eligible Special Needs Plan (D-SNP)

Who can join a D-SNP?

- Entitled to Medicare Part A (Hospital)
- Enrolled in Medicare Part B (Medical)
- Live in the plan service area
- Beneficiaries who are entitled to both Medicare and Medicaid

What Creates Success?

Focus on Prevention:

- Routine visits
- Individualized goals of care
- Early detection of changes in condition
- Medication management

Outcomes:

- Proactive
- Reduced avoidable Hospitalizations
- Reduced unnecessary ER Visits
- SNF (post-acute part A services)

Quality

- Provides clear quality indicators and reporting progress to CMS
- Monitors & works to continuously improve quality, appropriateness, and outcome of care
- Supports and promotes the mission, vision, and values of the Plan
- Engagement with the Plan Care Team*

As the Payer (instead of Traditional FFS Medicare), the Plan can pay for the visits, activities, and work that directly contributes to better care.

**Our model uses a "Care Team" approach. Depending on the needs of the Member and the LTC setting in which he or she lives, their primary care manager may be an Advanced Practice Provider (APP) or a Registered Nurse (RN) Personal Care Coordinator (PCC).*

What is the Model of Care?

The Model of Care (MOC) is Simpra Advantage's detailed, written commitment to CMS on how we will provide care to our enrolled members.

Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC).

Consist of 4 key Sections:

- **MOC 1**: Description of the SNP Population
- **MOC 2**: Care Coordination
  - SNP Staff Structure
  - Health Risk Assessment (HRA)
  - Individualized Care Plans (ICP)
  - Interdisciplinary Care Team (ICT)
  - Care Transition Protocols
- **MOC 3:** Provider Network
- **MOC 4:** Quality Measurement and Performance Improvement

MOC 1: Description of the SNP Population

This is a hypothetical depiction. The actual description is contained in the Model of Care applicable to the SNP population.

Medicare beneficiary	Frail /vulnerable	More likely to be female	Typically 65 years and older	Typically widowed or single
Often unable to make care decisions and participate in their own care	May be confined to a bed or wheelchair	Has multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)	Likely prescribed one or more high-risk medications per month	May need help with 5 or more activities of daily living (ADLs) including bed, mobility, dressing, eating and toileting (depending on senior housing location)
High likelihood of reporting daily pain	Has moderate to severe cognitive impairment	Overall low health literacy	Has socioeconomic issues creating barriers to care	Lacks consistent, engaged caregiver / family support

MOC 2: SNP Staff Structure

- Claims Processing moving from AllyAlign to RAM Technologies
- New Care Management System—Care Coach from Patient Pattern
- ACV Pharmacy Team direct connection with PBM, Navitus
- UM moving in-house
- Quality moving in-house

MOC 2: Care Coordination

- Health Risk Assessments (HRA)
- Individualized Care Plans (ICP)
- Interdisciplinary Care Team (ICT) Meetings
- Care Transition Protocols

Health Risk Assessment Tool (HRAT)

The Plan's Health Risk Assessment Tool starts the **new Member assessment** and care planning process for the Plan and provides an **annual checkpoint** and reassessment of key geriatric health metrics.

The Plan's Health Risk Assessment Tool is a screening tool used by the Plan to:

1. Collect Member self-reported or POA-reported health status
2. Identify potential gaps (medical, functional, cognitive, psychosocial, and mental health) in existing care and treatment plans and immediate care need
3. Monitor changes in self-reported health status on an annual basis

Health Risk Assessment (HRA)

MOC Requirements

- All new Plan Members receive an HRA **within 90 days of enrollment** effective date.
- An annual HRA is completed **within 364 days of their initial or last assessment**.
- The HRA **identifies immediate, chronic, and or other identified health needs** and drives the care plan for the Member.

Health Risk Assessment (cont.)

Results from the Health Risk Assessment directly contribute to a Member's Individualized Care Plan (ICP) in the following ways:

- The Plan will provide the HRAT information to the Interdisciplinary Care Team (ICT) members and Member/caregiver.
- Identification of potentially life-threatening conditions and/or conditions requiring an **immediate or near-immediate intervention** (i.e. thoughts of harming myself/others).
- Information from the HRA gives each member a "frailty score" which identifies members appropriate for Advanced Care Planning and helps set the **timing of the post-HRA visit** (for new Plan Members) or the next examination/visit date from the Plan Care Team.
- The Plan Care Team will complete a post-HRA visit. Visit will include:
  - HRA review *(Provider visit notes should include documentation of HRA results/outcomes)*
  - Review of available historical hospital, specialist, and diagnostic information
  - Comprehensive exam
- Outcomes of the post-HRA visit (i.e. medication changes, therapy referrals, diagnostic tests, scheduling of next visit, etc.), will be included in the medical record and **incorporated into the ICP.**

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Individualized Care Plan (ICP)

MOC Requirements:

- **Needs identified in the HRA** should be documented in the Individualized Care Plan annually.
- All SNP Members have an ICP that is updated with **significant changes in health status** and that is accessible to the Member and Care Team for updates.
- ICPs should be **reviewed and when necessary updates made**, at minimum:
  - Nursing Home: Quarterly
  - DSNP: Annually
  - Other Levels of Care: Bi-annually (Twice a year)

Care Plan Required Components:

Medicare Managed Care Manual:
(Chapter 5 Section 20.2.1)

Designed to address the needs identified in the HRA.

Services specifically tailored to the Member's need.

Roles/responsibilities of the Member's caregiver(s).

Should Contain SMART Goals:

S= Specific (direct, detailed, and meaningful)

M= Measurable (quantifiable to track progress or success)

A= Attainable/Achievable (realistic)

R= Relevant (aligns with the Member and/or ICT's goals)

T= Time-Based (deadline)

Measurable timelines and measurable outcomes.

Identification if goals are met/not met.

Barriers should be documented.

Beneficiary self-management goals & personal healthcare preferences.

Description of services specifically tailored to the beneficiary's medical, psychosocial, functional, and cognitive needs.

Describe how the ICP is **documented** and **updated** as well as, where the documentation is maintained to ensure accessibility to the ICT, provider network, beneficiary and/or caregiver(s).

Explain how updates to the ICP are communicated to the beneficiary/caregiver(s), the ICT, applicable network providers, other SNP personnel and other ICT members, as necessary.

Example: Care Coach Care Plan

ADVANCED CARE PLANNING NEEDS Priority 5 ACTIVE ⋮ Show less

CATEGORY

Other

RELATED DEFICITS

RELATED DIAGNOSES

Problem Created

Jennifer Gomez, RN on Nov. 14, 2022

Problem Last Modified

Jennifer Gomez, RN on Nov. 14, 2022

⊕ Add Goals

GOAL

MS REENERS AND/OR HER FAMILY Will participate in discussion and documentation regarding advance care planning.

Member Goal

Long Term

Due: Jun. 30, 2023

INTERVENTIONS

Discuss existing Advanced Care Plan and goals of care and assess if goals are still appropriate given trajectory of disease process.

Due: Jun. 30, 2023

⊕ Add Interventions

BARRIERS

No barriers yet.

⊕ Add Barriers

STATUS UPDATES >

Interdisciplinary Care Team (ICT) Meeting

- The Health Risk Assessment Tool is a **starting point** for the Plan to identify the different providers and support systems that the Member has in place and the role they play in the Member's overall care.
- The ICT is developed to ensure **effective coordination** of care, especially through the Member's care transitions, and to improve health outcomes.
- The **continuity** and **regular schedule of ICT meetings** allows the Plan Care Team to refine and re-evaluate the Member's ICP based on direct feedback from the ICT members.
- **Ad hoc meetings are scheduled as needed** with ICT members, the Plan Care Team, and other pertinent clinical staff to review and address **urgent issues**.
- The **exact composition of the ICT working with Members varies** and is dependent on each Member's unique circumstances, risk-level, and individual needs and preferences.
- ICT **members are selected based on their functional roles**, knowledge, and/or established relationship with the Member.
- The Plan Care Team and the ICT reviews **progress towards goals** during clinical and monitoring visits with the Member and during the ICT team meetings.

Interdisciplinary Care Team Meetings

The ICT schedule requires regular updates:

- Nursing Home: Quarterly
- D-SNP: Annually
- Other Levels of Care: 2x annually
- More frequently if needed

Interdisciplinary Care Team (ICT) Responsibilities

Member/Caregiver/ Responsible Party

- ICT process revolves around the Member
- Member can identify specific individuals they would like to participate in the ICT
- Participation in all HRAs
- Participation in the development of the ICP
- Vocalize needs, barriers, and prioritize goals
- Contact other ICT members for questions/concerns

Plan Care Team

- Responsible for ensuring that needs/gaps identified in the HRA or subsequent visits are addressed in the ICP
- Participates in the development of the ICP and ensures progress is being made to meet ICP goals
- Providing preventative services/primary care
- Conducts oversight for all transitions of care events
- Member education

Facility
(if applicable)

- May be various staff members (nurse, MDS coordinator, social worker, nutritionist, pharmacist, activity director, etc.)
- Communicate with all ICT members regarding changes in treatment or recommendations
- Provide input to the ICT for the ICP development and ongoing updates
- Ensure transition of care protocols are followed, including notification of transfers

Other Medical Professionals/ Specialist

- Each member of the ICT shares the responsibility for ensuring the Member's needs in relation to their specialty are met
- Communicate updates regarding changes in treatment/recommendations
- Provide input to the ICT regarding the development and ongoing updating of the Member's IPC
- Attend or provide input for ICT meetings, as appropriate

Interdisciplinary Care Team (cont.)

An effective ICT contributes to **improving the health status** of SNP beneficiaries through:

- Minimized errors and potential adverse events
- Improved care coordination, including during transitions
- Improved communication and understanding of health status and treatment across the team and with the Member and/or caregiver
- Improved management of the Member's medical, cognitive, psychosocial, and functional needs of the Member through collaboration and revision of the ICP
- Improved access to needed services and support as gaps in care and outstanding needs are identified
- Member and/or caregiver satisfaction with care planning process

Care Transition Protocols

The Plan understands how **coordinated health care improves the care of its vulnerable membership**. The Plan incorporates care transition protocols to provide an integrated, proactive approach to safely transition Members between levels of care and across care settings using evidence-based clinical practices and targeted strategies including (but not limited to):

- Ensuring that every Member has a Plan Care Team to serve as a **centralized point of care coordination** for Members and families/caregivers for all care, including transitions.
- The Plan Care Team will be responsible for preventive and primary care services.
- Minimizing the need for transitions through delivery of wellness, preventive, and monitoring services delivered in coordination with the ICT members.

Care Transition Protocols (cont.)

- **Waiving the 3-day hospitalization requirement** for Skilled Nursing Facility services, enabling skilled services without a prior hospital stay, and encouraging appropriate ER and Observation combined with follow up skilled services in the SNF instead of an inpatient hospitalization.
- **Following Members across care settings** during transitions (i.e. admission to a hospital) through the use of a Utilization Management Registered Nurse who coordinates discharge planning and post-discharge services with the hospital and Plan Care Team to ensure smooth transitions.
- **Identifying at-risk Members** through the HRA and reporting and notifying the Plan Care Team of status or status changes.
- Requiring Plan Care Team to provide **transitional care management visits** and communications.

Care Transitions (cont.)

An important goal in **continuity** of care processes for the Plan is to **reduce the incidence of inappropriate care transitions**, particularly those resulting in unnecessary hospitalizations. As part of the Plan's approach to ensuring a safe care transition process, the Plan focuses on the following:

Member-Centered Care

- The Plan Care Team oversees all care transitions
- Educate Member/caregiver as to the reasons for the transition
- Transitions consistent with the Member's goals and advance care directives

Communication

- Peer to peer communication is established across sites of care
- Information about the Member (i.e. medications and care plans) are collected prior, during, and post care transition

Safety

- Prompt and consistent medication reconciliation at every transition point
- Accurate and timely transition of key information (i.e. functional/cognitive status, current problem list, allergies, advance directives, recent labs, consultations, diagnostic testing results, etc.)

Transition Follow-up Timeline

The Plan Care Team is required to provide transitional care management visits and communications with the ICT.

Within 48 hours:

The Plan Care Team coordinates an **initial updated care plan** within **48 hours** of the Member's **return** to the facility or community.

Within 7 days:

The Member will have a visit with the Plan Care Team within **7 days** of the Member's **return** home or to the facility. An updated ICP will be coordinated with the ICT.

Transition Coordination & Communication

The Plan Care Team

- During the Interdisciplinary Care Team (ICT) meeting, the Plan Care Team updates the ICT on the Member's status and transition plan.
- Post-discharge, the Plan Care Team educates the Member and/or caregiver on the reason(s) for hospitalization/transition.
- Provides instruction on who to contact for concerns at any point in time.
- Provides instruction in recognition of warning signs for the disease processes and medications.
- Provides instruction on self-care to the degree possible.
- Discusses the next steps in the care management process (i.e. review updated ICP).
- Coordination of orders for post-hospital specialist visits, diagnostic testing, home health services and/or therapy.
- Coordinates post-transition follow up for the Member.

Care Transition Personnel

The personnel responsible for coordinating the care transition process include:

The Plan Care Team should be notified of all planned or unplanned care transitions with every effort made to consult with the Plan Care Team ***before*** the Member is sent to the hospital.

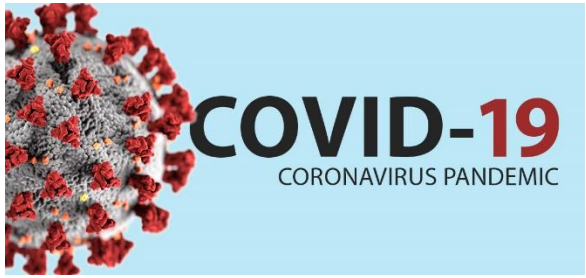
(I-SNP and IE-SNP only) The facility has the responsibility of notifying the Plan Care Team ***before*** an ***unplanned care transition*** or, when a Member requires immediate emergency services, right after contacting emergency services. The facility should also **notify the Plan of transfers to hospital** so that the Utilization Management team can ensure appropriate care level, engage in care coordination including exchange of patient information with the hospital, and begin discharge planning.

The Plan's Utilization Management (UM) team takes over the **care coordinator** role when Members are admitting to a short-term or long-term acute care hospital; or when Members are admitted to a non-contracted SNF.

The Clinical Coordinator (part of the UM team), coordinates care for Members who discharge from the contracted facility while the Member is pending disenrollment from the Plan. They ensure the Member received needed services and support (i.e. home health) during the transition, that the Member established a visit with the community based primary care, and record sharing (i.e. medication list and care plan) are disseminated to the new physician/facility.

Care Transition - Contingency Plan

- Natural disasters or public health emergencies can occur at any time. CMS requires SNPs and its healthcare partners to have a contingency plan to **avoid disruption in care and services** for members
- Disruption can be avoided when:
  - ✓ Administrative and Clinical employees are cross-trained to ensure continuity and can work remotely using web-based program on a secure network.
  - ✓ Calls are diverted to back-up offices within the Simpra network during an emergency.



MOC 3: Provider Network

- The Plan provides a comprehensive contracted network of providers, facilities, ancillary service providers, specialist physicians, and acute care facilities with the specialized clinical expertise pertinent to the care and treatment of individuals enrolled in special needs plans.
- Specialized expertise pertinent to the care and treatment of its Members (i.e., cardiologist, pulmonologist, neurologist, endocrinologists, etc.).
- Primary care services through the Plan Provider (MD, DO, NP, or PA) and supportive ancillary services like therapy, rehab, selected diagnostic radiology and lab, and home health are provided within the Member's home/community and coordinated by the Plan Care Team.
- The Plan Care Team coordinates visits and services provided outside of the Member's residence including specialist visits, radiology, lab, and other diagnostic testing.

MOC 4:
Quality Measurement and Performance Improvement

- The purpose of the Plan's Quality Improvement Program (QI Program) is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its Members, partners, and other stakeholders so that it may fully realize its vision, mission and commitment to Member care.
- The QI Program supports values of the Plan through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services to Members.
- The Plan's QI Program is assessed annually and reviewed by the Quality Improvement Committee (QIC) to determine the overall effectiveness of the program, including the MOC, and appropriateness of care and services furnished to Members. Enhancements are made to the QI Program based on the annual evaluation.

MOC 4:
Quality Measurement and Performance Improvement (cont.)

- The Quality Improvement (QI) Program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving the quality of care to Members.
- The QI Work Plan and Annual Evaluation are important materials used to guide Quality Improvement efforts.
- The Board of Directors (BOD) is responsible for the establishment, implementation and oversight of the QI Program.
- The Plan Chief Medical Officer provides oversight of the QI Program on an ongoing basis. The Plan Chief Medical Officer reviews and provides guidance on all QI activities.
- The Plan Chief Medical Officer chairs the Quality Improvement Committee.
- The Plan educates its network on key performance measures and changes to the MOC.

Model of Care Performance Goals/Metrics

Performance Description	Targeted Goal
Members newly enrolled will have HRAT completed within 90 days of enrollment effective date.	100%
Members who remain enrolled in the plan will have an annual reassessment completed within 364 days of the initial or last HRA.	100%
Members enrolled in the plan longer than 90 days will have an initial or updated interdisciplinary care plan (ICP) on file	100%
Member transitions will be evaluated by the Care Team within 48 business hours according to the Plan's transition care management procedure.	90%
Members will have a documented ICT meeting at least quarterly.	100%
Hospital Admissions rate per 1,000 person-years	≤ 450
Members meeting MTM qualifying criteria will receive a Comprehensive Medication Review (CMR).	90%
Grievances and appeals identified are referred to A&G to ensure Members' complaints/concerns are reviewed, and appropriate action initiated within the timeframe required per CMS guidelines.	100%

Thank you!